Return to CALC Attn: Admissions
141 Market Place, Suite #180 Fairview Heights, IL 62008 (618)398-2252
235 A East Center Dr .Alton, IL 62002(618)474-0616

Section 1 – Personal Information

Student completes this section.

Student Name (last, first, middle): _____

Street Address: _____ Phone Number: _____

City, State, Zip: _____ Date of Birth: _____

Section 2 - Medical History

Student completes this section. Medical examiner is encouraged to discuss with student.

Check all that apply – use the space below to provide details:

- ☐ Heart disease or heart attack
- ☐ Heart Murmur or Arrhythmia
- ☐ Fainting/dizziness
- ☐ Diabetes (specify control method)
- ☐ Thyroid disease
- ☐ Eye disorder/vision loss
- ☐ Ear disorder/hearing loss
- ☐ GERD, Crohn's disease, IBS, etc
- ☐ Any allergic reaction (drug, food, latex, etc.)
- ☐ Skin disease
- ☐ Back injury, scoliosis or chronic lower back pain
- ☐ Arthritis
- ☐ Orthopedic disorder
- ☐ Mental disorder/emotional instability
- ☐ Head injury
- ☐ Stroke or paralysis
- ☐ Headaches/migraines
- ☐ Neurological disorder
- ☐ Seizure disorder/Epilepsy
- ☐ Depression
- ☐ Shortness of breath, asthma, cough, or hoarseness
- ☐ Pulmonary disease
- ☐ Tuberculosis
- ☐ Cancer (specific type)
- ☐ Abnormal bleeding
- ☐ Major Surgery
- ☐ Other_____
- ☐ Other_____

Provide details form all boxes checked above (attach additional sheets if more room is needed):

_____

_____

_____

List any current medications or treatments (attach additional sheets if more room needed):

_____

_____

_____

Section 3 – Physical Examination

Medical Examiner (MD, DO, APN or PA) completes this section.

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

System:	Normal	Abnormal/Surgery (explain – attach additional sheets if more room is needed)
Cardiovascular	☐	☐ _____
Endocrine/Metabolic	☐	☐ _____
Eyes/Ears/Nose/Throat	☐	☐ _____
Gastrointestinal	☐	☐ _____
Genitourinary	☐	☐ _____
Integumentary	☐	☐ _____
Musculoskeletal	☐	☐ _____
Neurological	☐	☐ _____
Respiratory	☐	☐ _____

Section 4 – Immunizations and Tests (if needed)

Medical Examiner completes this section.

A **Two Step Tuberculosis Screening:** (Nursing students with proof of annual screenings need Step 1 only.)
Attach chest x-ray if any results are positive.

Step 1 date: _____/_____/_____ Results: _____/_____ Step 2 date: _____/_____/_____ Results: _____/_____

B **Tetanus: Must be within 10 years**

Date: _____/_____/_____

C **Measles, Mumps and Rubella:** Lab results for all titers must be attached if vaccine was not administered. Immune:

MMR Vaccine dose 1: _____/_____/_____
MMR Vaccine dose 2: _____/_____/_____

OR

Measles Titer: _____/_____/_____ Yes No
Mumps Titer: _____/_____/_____ Yes No
Rubella Titer: _____/_____/_____ Yes No

D **Varicella (Chicken Pox):** Indicate disease **or** titer **or** vaccine. ☐ Disease was contracted. (Requires clinical confirmation)

☐ Varicella Titer (attach lab results) Immune: Yes / No ☐ Vaccine Dose 1: _____/_____/____ Dose 2: _____/_____/_____

E **Hepatitis B Vaccine Series:** This vaccination series is **optional with student waiver** .

Student must start the 3 dose process (complete at lease one dose) **OR:** ☐ Student declines vaccine

Dose 1 Completed: _____/_____/____ Dose 2 completed: _____/_____/_____ Dose 3 completed: _____/_____/_____

F **Influenza Vaccine** (e.g., TIV, inactivated; LAIV, live attenuated) Date: _____/_____/_____

Type: _____ How Given: Subcutaneous / Intranasal (circle one)

Medical Examiner: Please complete

I Verify that I have reviewed this completed form with the student. I consider this student:

☐ Mentally and physically able to undertake this program ☐ Not mentally and physically able to undertake this program
Signature: _____ Printed Name: _____Date: _____
Office Address: _____ Office Phone: _____

Student: Read, Sign and Date

The information I have provided is complete and accurate to the best of my knowledge and I have attached all laboratory results. I understand that failure to complete this form correctly may jeopardize my participation in the clinical portion of this program.
Signature: _____ Printed Name: _____Date: _____